

## Language, Speech and Hearing Referral Parent Consent Form

**\*Please check one option below, sign and date it, then return this form  
to your child's classroom teacher.**

I, the parent (or guardian) of \_\_\_\_\_ DOB: \_\_\_\_\_  
attending \_\_\_\_\_ Public School. month/date/year

**I GIVE CONSENT** for the Speech Language Pathologist (SLP) to conduct an assessment of my child and to assist in planning any subsequent interventions. The following areas may be assessed:

- Hearing (headphones will be placed on your child's ears for this activity)
- Pronunciation, and how well others can understand your child's speech
- Mouth and oral movements (a tongue depressor may be used to see the back of your child's mouth)
- Use of words and sentences to interact and express needs, ideas, and tell stories
- Understanding of words, sentences, and stories
- Voice (pitch, loudness, quality)

Audio and /or video recordings shall only be used for diagnostic and /or educational purposes.  
Recorded information shall be treated as confidential material.

I understand that I have the right to be fully informed as to the results of this evaluation and/or any ongoing service provided.

Parental permission for this student-centered communication assessment and subsequent programming is valid for one year from the date of signature. I understand that I have a right to cancel my consent, in writing, at any time.

**I DO NOT GIVE CONSENT** for the Speech Language Pathologist to conduct an assessment of my child.

**I would like to use e-mail throughout the year to communicate about my child's programming. This may include receiving written documentation for my child such as speech language assessment reports, progress reports or parent letters by email.**

**My email address is: \_\_\_\_\_.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date